General Assembly

Raised Bill No. 5485

February Session, 2012

LCO No. **1788**

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Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-1083 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of sections 38a-1080 to 38a-1090, inclusive, as amended by this act, "purposes of the exchange" means the purposes of the exchange expressed in and pursuant to this section, which are hereby determined to be public purposes for which public funds may be expended. The powers enumerated in this section shall be interpreted broadly to effectuate the purposes of the exchange and shall not be construed as a limitation of powers.

(b) The goals of the exchange shall be to reduce the number of individuals without health insurance in this state and assist individuals and small employers in the procurement of health insurance by, among other services, offering easily comparable and understandable information about health insurance options.

(c) The exchange is authorized and empowered to:

(1) Have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) Adopt an official seal and alter the same at pleasure;

(3) Maintain an office in the state at such place or places as it may designate;

(4) Employ such assistants, agents, managers and other employees as may be necessary or desirable;

(5) Acquire, lease, purchase, own, manage, hold and dispose of real and personal property, and lease, convey or deal in or enter into agreements with respect to such property on any terms necessary or incidental to the carrying out of these purposes, provided all such acquisitions of real property for the exchange's own use with amounts appropriated by this state to the exchange or with the proceeds of bonds supported by the full faith and credit of this state shall be subject to the approval of the Secretary of the Office of Policy and Management and the provisions of section 4b-23;

(6) Receive and accept, from any source, aid or contributions, including money, property, labor and other things of value;

(7) Charge assessments or user fees to health carriers that are capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the operations of the exchange;

(8) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable;

(9) Invest any funds not needed for immediate use or disbursement

in obligations issued or guaranteed by the United States of America or the state and in obligations that are legal investments for savings banks in the state;

(10) Issue bonds, bond anticipation notes and other obligations of the exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes and mortgages of others;

(11) Borrow money for the purpose of obtaining working capital;

(12) Account for and audit funds of the exchange and any recipients of funds from the exchange;

(13) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers. The contracts entered into by the exchange shall not be subject to the approval of any other state department, office or agency, provided copies of all contracts of the exchange shall be maintained by the exchange as public records, subject to the proprietary rights of any party to the contract;

(14) To the extent permitted under its contract with other persons, consent to any termination, modification, forgiveness or other change of any term of any contractual right, payment, royalty, contract or agreement of any kind to which the exchange is a party;

(15) Award grants to Navigators as described in subdivision (19) of section 38a-1084, as amended by this act, and in accordance with section 38a-1087. Applications for grants from the exchange shall be made on a form prescribed by the board;

(16) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices;

[(17) Evaluate jointly with the SustiNet Health Care Cabinet the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;**]**

[(18)**]** (17) Sue and be sued, plead and be impleaded;

[(19)**]** (18) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the exchange; and

[(20)**]** (19) Do all acts and things necessary and convenient to carry out the purposes of the exchange, provided such acts or things shall not conflict with the provisions of the Affordable Care Act, regulations adopted thereunder or federal guidance issued pursuant to the Affordable Care Act.

Sec. 2. Section 38a-1084 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The exchange shall:

(1) Administer **[**the**]** a single exchange for both qualified individuals and qualified employers;

(2) Commission surveys of individuals, small employers and health care providers on issues related to health care and health care coverage;

(3) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, as amended by this act, of health benefit plans as qualified health plans;

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(5) Provide for enrollment periods, as provided under Section 1311(c)(6) of the Affordable Care Act;

(6) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange;

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on monies lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(8) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the Affordable Care Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(10) Inform individuals, in accordance with Section 1413 of the Affordable Care Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the

application by the exchange, that such individual is eligible for any such program;

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY Plan, Part A or any other state or local public program, to remain enrolled in a qualified health plan;

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

(13) Establish a program for small employers, which market shall be separate from the individual market, through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(14) Offer enrollees and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers;

(15) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(16) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under subdivision (15) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the Affordable Care Act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(17) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (16) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-

sharing or individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Affordable Care Act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(20) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Credit the amount, in accordance with Section 10108 of the Affordable Care Act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(22) Consult with stakeholders relevant to carrying out the activities required under sections 38a-1080 to 38a-1090, inclusive, as amended by this act, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(23) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 38a-1080 to 38a-1089, inclusive, as amended by this act, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications;

(24) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange; and

(25) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange.

Sec. 3. Section 38a-1085 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) Not later than May 8, 2012, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall select, and the General Assembly shall approve or reject, by resolution, a benchmark plan, as outlined in the Essential Health Benefits Informational Bulletin issued by the United States Department of Health and Human Services on December 26, 2011, as the standard for qualified health plans and plans sold outside the exchange.

(2) Not later than ten days after said committee makes such selection, the chairpersons of said committee shall file such selection with the clerks of the House of Representatives and the Senate. The General Assembly may approve such selection in whole by a majority vote of each house or may reject such selection in whole by a majority vote in either house.

(3) If the General Assembly rejects such selection, the matter shall be immediately returned to said committee to select another benchmark plan. Said committee shall not select a benchmark plan more than once. Not later than thirty days after such rejection, said committee shall file, and the General Assembly shall approve or reject, the selection in accordance with subdivision (2) of this subsection.

(4) If the General Assembly rejects such second selection, the matter shall be returned in accordance with subdivision (3) of this subsection, and continued until the General Assembly approves a selection.

[(a)**]** (b) The exchange shall make qualified health plans available to qualified individuals and qualified employers for coverage beginning on or before January 1, 2014, including to individuals (1) whose household incomes exceed one hundred thirty-three per cent of the federal poverty level but do not exceed two hundred per cent of the federal poverty level, (2) who are not eligible for medical assistance under Title XIX of the Social Security Act, as amended from time to time, and (3) who are under sixty-five years of age. The state shall not offer a basic health program, as described in Section 1331 of the Affordable Care Act.

[(b)**]** (c) (1) The exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code through the exchange, either separately or in conjunction with a qualified health

plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act.

[(c)**]** (d) Neither the exchange nor a health carrier offering health benefit plans through the exchange shall charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because (1) the individual has become newly eligible for that coverage, or (2) the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code.

Sec. 4. Subsection (a) of section 38a-1086 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan includes, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage requirements under **[**chapter 700c**]** the benchmark plan selected by the joint standing committee of the General Assembly having cognizance of matters relating to insurance and approved by the General Assembly pursuant to subsection (a) of section 38a-1085, as amended by this act, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection (e) of this section, if:

(A) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, as amended by this act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Affordable Care Act for catastrophic plans and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the Affordable Care Act, and if the plan is offered through the program for small employers, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the Affordable Care Act;

(5) The health carrier offering the plan:

(A) Is licensed and in good standing to offer health insurance coverage in the state;

(B) Agrees to offer at least (i) one qualified health plan at a silver level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, as amended by this act, and (ii) one qualified health plan at a gold level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, as amended by this act, through each component of the exchange in which the health carrier participates, where "component" refers to the program for small employers and the program for individual coverage;

(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or directly by the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties as set forth in subsection **[**(c)**]** (d) of section 38a-1085, as amended by this act; and

(E) Complies with the regulations developed by the Secretary under Section 1311(d) of the Affordable Care Act and such other requirements as the exchange may establish;

(6) The plan meets the requirements for certification pursuant to written procedures adopted under subsection (a) of section 38a-1082 and regulations promulgated by the Secretary under Section 1311(c) of the Affordable Care Act; and

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in the state.

Sec. 5. Subsection (a) of section 38a-1089 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Not later than January 1, **[**2012**]** 2013, and **[**annually thereafter until**]** January 1, 2014, the chief executive officer of the exchange shall report, in accordance with section 11-4a, to the Governor and the General Assembly on a plan, and any revisions or amendments to such plan, to establish a health insurance exchange in the state. Such report shall address:

[(1) Whether to establish two separate exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single exchange;

(2) Whether to merge the individual and small employer health insurance markets;**]**

[(3)**]** (1) Whether to revise the definition of "small employer" from not more than fifty employees to not more than one hundred employees;

[(4)**]** (2) Whether to allow large employers to participate in the exchange beginning in 2017;

[(5) Whether to require qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or include additional state mandated benefits;**]**

[(6)**]** (3) Whether to list dental benefits separately on the exchange's Internet web site where a qualified health plan includes dental benefits;

[(7)**]** (4) The relationship of the exchange to insurance producers;

[(8)**]** (5) The capacity of the exchange to award Navigator grants pursuant to section 38a-1087;

[(9)**]** (6) Ways to ensure that the exchange is financially sustainable by 2015, as required by the Affordable Care Act including, but not limited to, assessments or user fees charged to carriers; and

[(10)**]** (7) Methods to independently evaluate consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-1083
Sec. 2	*from passage*	38a-1084
Sec. 3	*from passage*	38a-1085
Sec. 4	*from passage*	38a-1086(a)
Sec. 5	*from passage*	38a-1089(a)

Statement of Purpose:
To make various changes to the duties of the Connecticut Health Insurance Exchange, to require the Insurance and Real Estate Committee to select the benchmark plan for purposes of establishing the standard for qualified health plans and plans sold outside the exchange and to require the General Assembly to approve such selection.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]